The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XXXVI, No. 3 March, 1953

TABLE OF CONTENTS

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVI MARCH, 1953 NO. 3

MEDICO-LEGAL ASPECTS OF HAND DERMATOSES

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OCCUPATIONAL DERMATOSES occur more frequently than all other occupational diseases combined.[1] Among these dermatoses, those affecting the hands are the most common. Nevertheless, the most perplexing problem confronting an impartial examiner (one appointed by the Compensation Board) is determining when a chronic dermatosis on the hands is occupational. It may be impossible to absolutely and scientifically judge every case. However, where final judgments may be inconclusive at scientific meetings, in textbooks, etc., this does not apply to courts. Judges place the pros and cons of a case on the scales of justice and render a decision.

The cases of short duration present little difficulty, since insurance companies may decide not to contest a case when amounts involved are small; the reverse is just as frequently true, where the patient and also the doctor will consider litigation too burdensome for the compensation involved.

Before the more important aspects are considered, it would be well to briefly discuss some of the more common dermatoses afflicting the hands.

Psoriasis: Characterized by discrete and coelescing, erythematous, desquamative, well-marginated lesions, prone to chronicity with sites of predilection on extensor surfaces, but not infrequently of generalized distribution. Etiology is unknown but confinement to palms may raise question of compensibility. In a cobbler, etc., the repeated friction of tools may be a contributing factor acting as a trigger mechanism in a patient with a psoriatic predisposition.

Pompholyx: Clusters of pruritic, symmetrical, deeply-situated vesicles, usually involuting spontaneously within a fortnight but occasionally associated with remissions. Etiology is varied and obscure but many cases are associated with hot weather. If recurrences are incapacitating, and there is exposure to unusual heat (open furnaces, etc.) it is essential to eliminate these exposures and thereby determine the role of the occupation.

Infections: Ecthyma, Dermititis Repens and Impetigo may complicate and follow in the wake of an injury but the modern anti-biotics usually significantly reduce the resulting incapacitation.

Foods: Proclaimed by a few but denied by many as etiological factors in adults, particularly in dermatoses confined to the hands. The methods of proving are cumbersome and unreliable. In general, foods play a minor role in differential diagnosis in hand dermatoses.

Dermatophytosis: The eczematous and scaly types are most prevalent on the hands. In the former, initial vesiculation progresses to crusting. Later with an active, vesicular periphery and no attempt at central clearing, ill-defined lesions may form. The scaly type shows ill-defined, branny scaling with slight redness. The response to fungicides, the finding of mycelia in direct smear and the culture growth assist in diagnosis. It is not occupational unless proof exists of an active focus in a fellow worker[2] or where wet work prepared the soil as, for example, in Erosio Interdigitalis Blastomycetes.

Dermatophytids: Vary widely in clinical forms and severity. On the hands usually vesicular and associated with active focus on feet usually being irritated by treatment. Unlike primary, no fungi can be isolated. Usually disappear when focus on feet is eliminated. The positive trychophyton test is of variable significance. It is non-occupational unless the foot lesions are attributable to a particular work.

Neurodermatitis (Lichen Chronicus Simplex of Vidol): Sharply-marginated, pruritic, irregular-sized patches of subacute inflammation. Discrete papules at periphery may coelesce towards the center with resulting induration, desquamation and exaggerated skin markings. Basically it is not occupational since it may result from focal infection, underlying protaplasmic irritability or emotional tensions.

continued on next page

Atopic: Many cases follow morphology of neurodermatitis. However, there may be an atopic background (hay fever and/or asthma). Often there is a history of previous involvement of other areas such as cubitol and popliteal fossae, etc. Basically are non-occupational.

Nummular eczema: Round or oval patches of vesicles or vesico-crusts especially on dorsa of hands, recalcitrant and associated with remissions and exacerbations. Cause is unknown but may be associated with focal infection. Basically it is not occupational.

Pustular Bacterid: Clusters of deeply-seated vesicles which may progress to cloudiness. These erupt in showers and new ones may be appearing while old ones are involuting. It is non-occupational and prone to chronicity unless distant foci are eliminated. Basically it is not occupational.

Contact: It is not the purpose of this paper to discuss in detail each contact associated with various industries. Some are characteristic of the industry, but many are of the non-specific eczematous type. Basically and usually in acute phase there are areas of erythema, oedema and vesiculation varying in degree and extent dependent on sensitivity of patient's tissue, duration of exposure and concentration of offending agents. It must be repeatedly and strongly emphasized that the same picture may be produced by exposures at work as with non-occupational exposures at home. The history, the type of work, the improvement on absence from work, the exacerbation on further exposure, the patch-tests and the outside activities all individually or collectively assist in making a diagnosis. Usually an occupational case will involute in less than two to three months with absence from work unless complications develop.

If cases seen by an impartial examiner could always be precisely and uncategorically classified in above groups the problem of determining whether a dermatosis was occupational would indeed be simplified. Unfortunately, such is not the case and WE NOW COME TO THE HEART OF THE PROBLEM, i.e., cases away from work that linger on beyond two or three months with remissions and exacerbations. These cases are not necessarily typical of neurodermatitis, pustular bacterid, atopic eczema and contact dermatitis but may be confounded and altered by scratching, inconclusive histories, foci of infection, injudicious treatment, concomitant infection, disturbance of the psyche and the many ordinary contacts to which the hands are daily subjected. These factors acting individually or collectively and synergistically may have a tendency to make the eczemas indistinguishable from one another. Morphologically they may tentatively be classified under the term chronic eczema, subacute eczema or at times infectious eczematoid dermatitis.

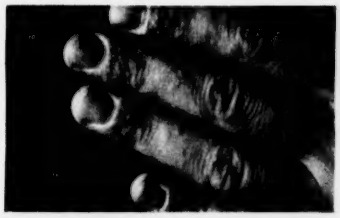
We now digress to the opinions of others relating to dermatoses lasting over two to three months even though the patient is away from work. Sulzberger and Finnerud state,[3] "Among the long recognized examples of synergy, we may mention first the fact that one allergen may sensitize the skin and that this first sensitization may be observed by some unknown mechanism, to pave the way or bring in its train a subsequent sensitization to a second or third or greater number of perhaps entirely unrelated allergens." In other words, this concept would explain why some eczemas persist over three months even though the patient is away from his work. Sulzberger[4] in another work states, "While this is usually the case (disappearance after days, weeks, or months) retention of causal agents, complications or ensuing polyvalent sensitization may prolong the course for several years after the last industrial exposure."

Grolnick's[5] tests substantiated Sulzberger's views and he revealed, ". . . that a healed site of specific dermatitis is more reactive or responsive to a secondary chemical stimulus than is uninvolved skin and that the effect of the latter may be nonspecific." This could explain why a dermatosis did not disappear in a reasonable time even though patient was away from original offending allergens. Furthermore, it would mean that the original dermatosis paved the way for subsequent sensitization.

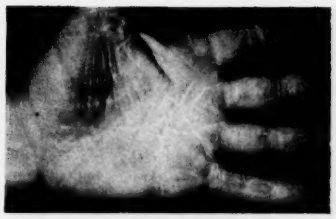
Somewhat contrary opinions are expressed by others. White[6] states that, "If an eruption be continuous or repeat itself when the offending agent is completely withdrawn, it points to the fact that the chemical is not the predominating, or causal factor in its repetition or continuance, etc. At any rate, in cases which extend over months or years, the proof should be borne justly by the plaintiff. It cannot logically be credited to the original agent." However, White[7] quotes McLeod, Legge, Gardiner et al who individually reported cases that persisted even though the original offending agent had been removed from the environment.

Schwartz, et al[8] state where it is implied "that the worker originally developed a dermatitis as a result of becoming sensitized to some substance encountered in his occupation, following which he developed a polysensitivity—that is he also became hypersensitive to substances encountered elsewhere than in his occupational environment. Subsequently, and prior to the time of patch-testing he lost his original hypersensitivity to substances encountered at his occupation but retained his hypersensitivity to the substance encountered away from his occupational environment. This contention should not be supported," they state, and continue, ". . . it is true that if such a worker shows a positive reaction to a patchtest with any of the substances which he en-

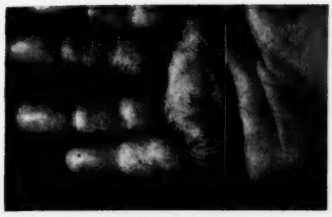
Psoriasis



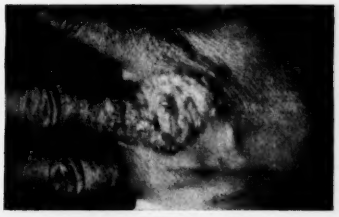
Pompholyx



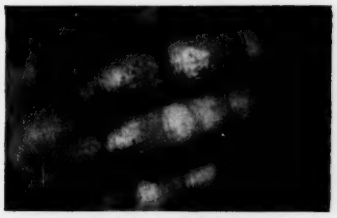
Dermatophytosis



Atopic

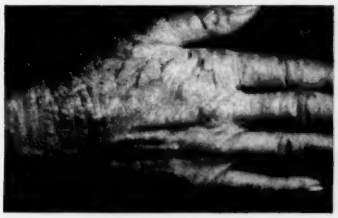


Nummular Eczema



Pustular Bacterid

Contact (Acute)



Chronic Eczema

Infectious Eczematoid Derm.

countered in the course of his work, his occupation should be considered to be at least a contributory cause of his dermatitis; but if the patchtests with these substances are negative, or are not performed, then the occupational etiology of his dermatitis has not been established and is open to question." However, in discussing the interpretation of patchtests in a different section of their book[9] they state, ". . . a negative patchtest does not necessarily rule out the test substance as a caustive agent. The negative reaction may be due to one of three causes:

1. Under the conditions of the patchtest the actual mechanism which produces the dermatitis is lacking, i.e., the patchtest does not equal actual condition of wear, exposure, friction, perspiration, etc.
2. The patient is no longer sensitive
3. The actual sensitizer was not applied."

There are other opinions but I believe the above are representative.

It is obvious that with these conflicting opinions on a most relevant aspect, the impartial examiner must at times conclude his report with statements such as, "to a major degree" or, "the preponderance of evidence" indicates it is or is not occupational. In certain cases, where the etiology cannot be conclusively proven, is prone to chronicity, with remissions and exacerbations, possesses a reasonable resemblance to known occupational eczema, then the courts may resolve the uncertainties of the medical conclusions and rule in favor of the patient who works with his hands and is employed in an industry with known occupational hazards. Until more unassailable scientific facts are forthcoming, it would seem that this disposition harmonizes most with a sense of fairness.

SUMMARY

The more common dermatoses of the hands have been described. The pros and cons of their occupational aspects when persisting over two or three months even though away from work have been discussed.

BIBLIOGRAPHY

[1] Schwartz, Lewis; Tulipan, Louis; Peck, Samuel M.: Occupational Diseases of the Skin, p. 17.
[2] Lewis, George M.: Introduction to Medical Mycology, 1939, p. 180.
[3] Sulzberger, Marion B. and Finnerud, Clark W.: Industrial Dermatoses, American Medical Journal 1938, p. 39.
[4] Sulzberger, Marion B.: Dermatologic Allergy—1940, p. 467.
[5] Grolnick, Max: Studies in Contact Dermatitis, Journal of Allergy, p. 302, Volume 19, Number 5, September 1948.
[6] White, R. Prosser: The Dermatergoses or Occupational Affections of the Skin—1934, p. 46.
[7] White, R. Prosser: The Dermatergoses or Occupational Affections of the Skin—1934, p. 44.
[8] Schwartz, Lewis; Tulipan, Louis; Peck, Samuel M.: Occupational Diseases of the Skin—1947, p. 905.
[9] Schwartz, Lewis; Tulipan, Louis; Peck, Samuel M.: Occupational Diseases of the Skin—1947, p. 308.

THREE YEARS OF VOLUNTARY PREPAID SURGICAL INSURANCE IN RHODE ISLAND*

JOSEPH C. O'CONNELL, M.D.

The Author. *Joseph C. O'Connell, M.D., of Providence. President, Rhode Island Medical Society Physicians Service; Past President, Rhode Island Medical Society.*

THREE YEARS ago the Rhode Island Medical Society Physicians Service wrote its first contract. At the end of 1952 a total of 314,560 persons were subscribers to the program, representing approximately 42 per cent of the population of the State eligible for coverage.

That record makes our program in Rhode Island one of the four leading ones of the nation as regards the percentage of eligible population protected with surgical-medical insurance under a medical society sponsored program.

We are proud of our accomplishment over the past three years. However, the mere recitation of enrollment figures does not begin to explain the great contribution that has been made by the physicians of Rhode Island to aid the people of this State in the problem of the distribution of the costs of surgical-medical insurance. There are other factors in the program that warrant reporting if the true significance of our endeavor is to be known.

Perhaps I can best report these factors regarding Physicians Service and the Rhode Island Medical Society by answering in part some of the points raised in the recent report of the President's Commission on the Health Needs of the Nation relative to private prepayment plans.

This Commission has expressed its belief that the correctness of the prepayment principle has been demonstrated by the private plans presently in operation. But it lists as inadequacies in the plans the following:

1. They have not proven their ability to meet adequately the need for prepaid personal health services, and they limit their benefits to hospital and surgical care.
2. Many of them offer only cash indemnity for medical expense, a method of compensation which often does not cover the full charge and which lends itself to a variety of abuses.
3. They often exclude pre-existing conditions.
4. Their control is usually such as to preclude consumer representation in policy-making.
5. They require a flat premium rate, irrespective of income.
6. They do not bring prepaid protection to small groups, and the self-employed.

Let us review these reported inadequacies as they apply to the situation in Rhode Island.

Our programs, both Physicians Service and the Rhode Island Plan operated by private insurance companies, were initiated to increase the extent to which voluntary insurance against the cost of medical care is made available to the people of Rhode Island at the lowest practicable cost. We sought first to provide an insurance protection against major and catastrophic illnesses necessitating surgery and long-term hospital stay for sickness. We have sought to provide protection against unexpected economic demands upon the individual families.

The theory of the President's Commission that our plans should seek to provide protection against the total cost of personal health services, which it lists as preventive services, diagnosis, treatment, and rehabilitation, outside as well as in the hospital, is an ideal to which we may all aspire. But in a practical world beset with tremendous governmental taxation upon the family income it requires no expert actuarial knowledge to realize that the premium charge for a comprehensive program—provided such a plan could be made workable—would be far beyond the means of the 48 per cent of the nation's families whom the Commission cites as earning $3,000 or less annually.

Ours is one of the many plans in the country that is a combined service and indemnity program. For all families whose annual income is $3,600 or less, our physicians have agreed to accept the payment from our plan as the fee for the surgical procedure performed. For those above the specified income limits the indemnity principle prevails, with the physician reserving the right to charge the patient the difference between the payment from our plan and his usual fee.

*An address to the Corporation of the R. I. Medical Society Physicians Service at the 4th Annual Meeting, at Providence, R. I., January 21, 1953.

Every subscriber who receives benefits from our plan receives a statement of the payment made to his physicians, and also a letter from me personally inviting correspondence with us if there is any question whatever with the service rendered or the payment made.

What other organization, profit or non-profit, professional or otherwise, today renders a service such as we do to the people of our State through Physicians Service?

The Commission expresses concern about the pre-existing condition provision in prepayment insurance contracts for surgical-medical care. But it evidently forgot that the same principle of preventing unfair utilization of public funds by a minority that we employ is the pattern also in all governmental programs, such as social security and our State temporary disability compensation plan. Until actuarial data and reserve funds are sufficiently available we probably cannot waive the pre-existing clause for all contracts, although we have for those employees enrolled through companies employing twenty-five or more when 90 per cent or more employees subscribe.

From the beginning we have included consumer representation in the policy-making procedures of Physicians Service. Six of our eighteen directors have to be other than physicians under the provisions of our By-Laws. To these business men who have given liberally of their talents and time to help us make our plan the success it is we are truly indebted.

The President's Commission criticizes a flat premium rate, regardless of income. Again the inconsistency arises, for the Commission is evidently unmindful of the systems of taxation for federal old age and survivors insurance, and of such state plans as ours for temporary disability compensation that make the same premium charge on all, but offer a sliding scale of benefits. Physicians Service utilizes the principle of a flat premium rate, but it guarantees the same indemnity payment to every subscriber, a far more equitable arrangement than the governmental programs to which the Commission may look with favor.

Finally the Commission points to the failure of plans to consider the self-employed, or the worker in the small group. We call to your attention that Physicians Service started by enrolling groups of ten employees, and offered individual membership to dependents of employed persons who attained the age of nineteen years, and to persons leaving a place of employment and remaining unemployed.

In the past two years we have opened up our program to provide individual enrollment, with no age limit, for any person in the State who might be self-employed, or unemployed. The direct enrollment campaign in 1952 brought in 6,060 contracts and 12,671 new subscribers. As a result we have compiled in the past two years a total of 71,298 persons as direct subscribers.

Measured by the standards which the Commission on the Health Needs of the Nation has set forth regarding voluntary pre-payment programs it is apparent that the Rhode Island Medical Society Physicians Service ranks in top position as an insurance program in the best interests of the public. We recognize inadequacies in our program, and as we progress we shall eliminate them and make the Service more comprehensive. Our three year achievement, however, stands as a monument to the community service that has been rendered the people of Rhode Island and adjoining areas by our 770 participating physicians. The success of Physicians Service rightfully belongs to these doctors, and to no one else.

All citizens are hopeful that the future trends will be away from governmental controls, and towards a resumption of the education of the individual citizen to his personal responsibilities. It was most heartening to the medical profession which has for years advocated the right of the individual, to note that the point is made forcefully in the report of the Commission on the Health Needs of the Nation that:

> "The individual effort of an informed person will do more for his health and that of his family than all the things that can be done for them. In the past, measures for health maintenance demanded individual responsibility only to a limited degree. The development of pure water supplies, pasteurization of milk, and other sanitary accomplishments were achieved through social action in which the individual may have participated as a citizen, but was required to take no further individual responsibility.
>
> Future accomplishments, however, depend to an even greater degree upon the individual's assumption of responsibility for his own health. It is the individual who must consult his physician for early care, avoid obesity and alcoholism, and drive his automobile safely. These things cannot be done for him. They require both information and motivation. Personal health practices which are determined by the individual's knowledge, attitude and decision have now become of paramount importance in gaining health. Effort by each person to improve his own health can be expected to pay great returns."

I add to this that the responsibility for providing medical care insurance by the individual when he is well is equally his responsibility. The motivation to avoid possible future financial obligations is present. Physicians Service offers an outstanding low-priced medium through which to secure that

concluded on page 142

SULFONAMIDES AND PENICILLIN IN THE CONTROL OF RHEUMATIC FEVER IN CHILDREN*

BANICE FEINBERG, M.D.

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Introduction

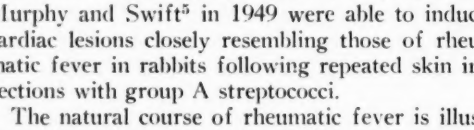
THIS IS THE FIRST in a series of articles presenting the results of experiences with rheumatic fever over a period of twenty-five years. The small size of the state of Rhode Island with its relatively large Providence population makes our local experiences at R. I. Hospital fairly representative.

The etiology of rheumatic fever has not been conclusively established but there is overwhelming evidence that the hemolytic streptococcus plays an important role both in the development of the disease and in the precipitation of recurrences. A comprehensive review by T. N. Harris[1] in 1948, and studies by Rantz, Spink and Boisvert,[2] Homer Swift,[3] Windblad, Malmiros and Urlander[4] in Scandinavia have been added to the vast literature. Murphy and Swift[5] in 1949 were able to induce cardiac lesions closely resembling those of rheumatic fever in rabbits following repeated skin infections with group A streptococci.

The natural course of rheumatic fever is illustrated in Table I. The inciting infection, or trigger mechanism, with beta hemolytic streptococcus

TABLE I

Nature of Rheumatic Fever



rarely lasts more than ten days. This initial phase is followed by a period of apparent recovery which varies from a few days to several weeks. This, in turn, is followed by the appearance of acute rheumatic fever, carditis, improvement, further streptococcal infections, recurrences, further cardiac involvement, congestive failure and ultimately death.

It became inevitable that the advent of chemotherapeutic agents and antibiotics would result in attempts to eliminate hemolytic streptococcus especially in those who were particularly prone to recurrent attacks of rheumatic fever.

Sulfonamide Study

The effectiveness of sulfonamides in small daily dosage over a period of years, in preventing recurrences of rheumatic fever has been demonstrated by an imposing number of investigators all over the world.[6,7,8,9,10] At a conference at the White House in 1942, many prominent rheumatologists reported an apparent 75% reduction by sulfa prophylaxis in the recurrence of rheumatic fever. In England, in 1949, Rublio and his associates[11] reported a recurrence rate in 211 children age 4 to 14 years on small daily doses of sulfonamides for 565 person years of 3.2%. In a control group of 337 closely matched and studied simultaneously for 971 person years, the recurrence rate was 11.8%.

Kuttner[9] in 1943, at the Irvington House, demonstrated a sharp reduction in the incidence of recurrences with the aid of prophylactic sulfonamide. In 1947, Baldwin[12] reported on 2 years' experiences with 102 patients at Bellevue Hospital in New York City, 51 of whom received sulfadiazine while 51 others were used as controls. There was one recurrence in the prophylactic sulfadiazine group and 6 recurrences in the control group. In 1949, Lyon[13] reported a 4.6% recurrence rate in 152 cases treated with sulfadiazine prophylaxis using only 0.5 gm. once daily.

At the Rhode Island Hospital Children's Cardiac Out-Patient Department, in a survey made by the

TABLE II

Recurrence Rate in Rheumatic Fever, 1925-1940
(Pre-sulfa prophylactic era)

No. of children with Rheumatic Fever at R.I.H.O.P.D. (1933-1940)	147	
No. of children having recurrences	41	(28%)
No. of R.F. cases seen privately	48	
No. of these having recurrences	10	(21%)
Total No. of cases of Rheumatic Fever	195	
Total No. having recurrences	51	(26%)

*From the Department of Pediatrics, Rhode Island Hospital, Dr. Robert M. Lord, Chief; and the Rhode Island State Rheumatic Fever Program, Dr. Francis V. Corrigan, Chief.

author[14] in 1940 of 147 cases of rheumatic fever from 1933-1940, 41 children (28%) were known to have had one or more recurrences. The total number of recurrences was 66.

Since 1941 the State Rheumatic Fever Program has been conducting several clinics in Rhode Island. Sulfonamide prophylaxis has been carried out in a few of these clinics in varying methods and dosage. At his clinic in Providence, the author had originally used sulfadiazine in dosage of 0.5 gm. twice daily, and later sulfamerazine in dosage of 0.5 gm. once daily. 138 cases of rheumatic fever were studied. 49 of these youngsters were put on sulfonamide prophylaxis. 24 of these children gave a history of previous recurrences. Because of leukopenia in 3 cases where the white blood count went below 4,000, rashes in 2 others, and hematuria in another, 6 children were taken off sulfa and not classed under the prophylactic group. None of these children required specific therapy and it is conceivable that they may have been able to tolerate sulfa if we had persisted in its use. There were several other instances where, because of poor cooperation, the drug was discontinued. These also were not classified among the prophylactic group.

Of 89 children not receiving sulfa prophylaxis, 26 (30%) developed a total of 71 recurrences. Of 49 receiving sulfa prophylaxis there were 3 recurrences, a rate of 6.1%.

These youngsters were on sulfa prophylaxis for periods of one to five years and have been under observation up to ten years, in no case less than 3 years. 3 children developed recurrences 3 months to 2 years after being taken off prophylaxis. Prophylaxis was automatically discontinued at 14 years of age, since it was felt that the possibility of recurrences was greatest before adolescence. In no case was prophylaxis instituted unless the diagnosis was definitely established. No recurrence was classified as such unless the same criteria were used as in making the diagnosis of rheumatic fever. Polyarthritis, characteristic murmurs, fever, elevated sedimentation rate, prolonged conduction time, carditis, erythema marginatum, nodules, x-ray appearance of the heart and a definite history of previous rheumatic infection were the principle criteria.

Also included is a résumé of cases seen in private practice over a period of 27 years since 1925, see Tables II and III. Though this group is not large, the results are similar and indicate a sharp reduction in the recurrence rate while on sulfonamide prophylaxis. Table IIIC which includes the total number studied from 1941-1949 reveals recurrence rate of 28.5% in the non-prophylactic group and a rate of 5.4% amongst those receiving prophylaxis.

Results of this survey indicate that sulfonamide prophylaxis was able to appreciably reduce the expected recurrence rate of rheumatic fever.

TABLE III

Sulfonamide Prophylaxis 1941-1949

A. STATE RHEUMATIC FEVER PROGRAM (R. I. HOSP. CLINIC)		
No. of children with Rheumatic Fever	138	
No. not receiving prophylaxis	89	
No. of these developing recurrences	26	(30%)
No. receiving sulfa prophylaxis	49	
No. of these developing recurrences	3	(6.1%)
B. OTHER SOURCES (Private Cases)		
No. of children with Rheumatic Fever	26	
No. receiving sulfa prophylaxis	24	
No. of these developing recurrences	1	(4.2%)
C. TOTALS		
Total No. of children seen with R.F.	164	
No. not receiving prophylaxis	91	
No. of these developing recurrences	26	(28.5%)
No. receiving sulfa prophylaxis	73	
No. of these developing recurrences	4	(5.4%)

Penicillin Study

In 1949 oral penicillin in 200,000 unit dosage daily, replaced sulfonamide prophylaxis. Since 1947 reports of similar success with penicillin have begun to appear in the literature. Maliner and Amsterdam[15] in 1947 discussed the use of oral penicillin in the prevention of rheumatic fever recurrences. In the same year Goerner, Massell and Jones[16] found that penicillin in dosage of about 1,200,000 units administered over a period of 10 days was successful in permanent elimination of the hemolytic streptococcus from positive throat cultures in about 90-95% of the cases. Similar results were obtained with the use of daily injections of a slowly absorbable form of penicillin for 10 days. In 1948 Massell, Dow and Jones[17] found that orally administered penicillin in doses of 300,000-1,000,000 units per day for 10 days suppressed H.S. in throats of all but 2.1% of patients with rheumatic fever during therapy.

For many years children convalescing from rheumatic fever were sent to the Crawford Allen Memorial Hospital, a unit of R. I. Hospital, on East Greenwich Bay, for further care. Since 1943 most of the cases under the care of the State Rheumatic Fever Program needing convalescent care have been referred to Crawford Allen, and have remained from 3-24 months. Bcause of its location 16 miles from the parent institution, and several miles from the nearest center of population, contact with respiratory infections and the hemolytic streptococcus is at a minimum. However, periodic episodes of respiratory infections with frequent positive H.S. throat cultures do occur. Cultures are taken of all children and personnel weekly and more often when indicated. The number of throat cultures done yearly in the past 10 years has been approximately 2500-3000.

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Positive H.S. throat cultures have always presented a serious problem. Our isolation rooms were always occupied and a great deal of added personnel care was needed. Sulfonamides, and later penicillin troches, and gum were used in attempts to eradicate these positive cultures. In late 1946 aqueous penicillin intramuscularly was administered to all positive cultures. Beginning with 20,000 units every 3 hours, and later 40,000 units every 4 hours for 5 days, it was found that positive cultures became negative in 80% in 48 hours and over 98% in 96 hours. In 1947 and 1948 approximately 4,500 cultures were taken of which 104 were positive for H.S. 81 were negative 48 hours after the administration of 40,000 units every 4 hours. This was continued for a total of 5 days. At the end of 96 hours 102 were negative. Of the 2 failures one became negative after another 5 days course of treatment, while the second one remained positive most of the time until his tonsils and adenoids were removed 3 months later.

Later, similar results were obtained by the use of the longer acting procaine penicillin preparations. In view of our experience that approximately 1,000,000 units was found necessary to eliminate H.S. from these throats, 3 daily doses of 300,000 units of procaine aqueous penicillin were given. In 1949, of 72 positive cultures 68 were negative after 48 hours, 3 more became negative after 96 hours and one was found to be resistant to penicillin but responded promptly to aureomycin.

In an attempt to reduce the number of injections and lower the work load of personnel, the dosage was next changed to one 900,000 unit dose of procaine penicillin. In 1950, of 66 positive cultures treated in this manner, there was only one failure; but this became negative after a repeat dose of 900,000 units.

In 1951 and 1952 the dosage was reduced to one 600,000 unit dose of procaine penicillin. Of 131 positive cultures there were 4 failures in 48 hours. 3 of these responded promptly to a second 600,000 unit dose, while the last one became negative after daily 600,000 unit doses for 1 week.

No positive culture was considered successfully treated unless it remained negative on 3 successive subsequent weekly cultures.

In our experience, with the exception of the two youngsters noted above, one who responded to aureomycin and the other to tonsillectomy, none of our patients have developed penicillin resistance.

At present, the routine is to give all positive cultures 600,000 units procaine penicillin, and if they are not negative in 48 hours, the dose is repeated.

Since the adoption of this routine our isolation problem has become negligible, the load on personnel lightened, and the incidence of recurrence at the hospital almost nil.

TABLE IV

Penicillin Suppression of Positive H.S. Throat Cultures at Crawford Allen Hospital—1946-1952

Penicillin Type & Dose	*1946-1948 Aqueous 40,000 U. Q. 4 h.—5 days*	*1949 Procaine Aqueous 300,000 U. once daily—3 days*	*1950 Procaine Aqueous 900,000—one dose only*	*1951-1952 Procaine Aqueous 600,000—one dose only*
Total Units	1,200,000	900,000	900,000	600,000
Positive H.S. Cultures	104	72	66	131
Negative after 48 Hrs.	81(80%)	68(94%)	65(99%)	127(97%)
Negative after 96 Hrs.	102(98%)	71(99%)	65(99%)	128(98%)
Failures	2	1	1	3

SUMMARY

1. In 195 cases of rheumatic fever between 1925-1940 in the pre-sulfonamide prophylaxis era the recurrence rate was 26%.

2. Of 138 cases of rheumatic fever at one of the largest State Rheumatic Fever Program clinics in Providence between 1941-1949, 49 were put on sulfonamide prophylaxis. In the non-sulfa group the recurrence rate was 30% while in the sulfa prophylaxis group the rate was 6%.

3. Since 1949 oral penicillin 200,000 units daily has replaced sulfonamides in prophylaxis.

4. At Crawford Allen Memorial Hospital, varying methods of penicillin administration were employed in eradicating H.S. from positive throat cultures. 40,000 units every 4 hours for 5 days, procaine aqueous penicillin 300,000 units daily for 3 days, procaine aqueous penicillin 900,000 units for 1 dose and the same preparation in one dose of 600,000 have all been highly successful.

5. Over a period of 6 years there have been 393 positive cultures among 15,000 throat cultures. There were only 7 failures after 96 hours when approximately 1,000,000 units penicillin were given. Of these 1 needed aureomycin, another a T& A,while the others responded to repeat doses of penicillin.

Conclusions

Eleven years of experience with sulfonamides and penicillin prophylaxis in rheumatic fever in Rhode Island warrants the following conclusions:

1. Sulfonamide prophylaxis is successful in markedly reducing the incidence of recurrences in rheumatic fever.

2. Penicillin in large doses is very effective in quickly eliminating H.S. from positive throat cultures.

3. One dose of 600,000-900,000 units procaine aqueous penicillin will suppress positive H.S. cultures in 99% of the cases in 48 hours.

concluded on page 142

13TH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

— *Held at Chicago, Illinois, January 20-22, 1953* —

Report of STANLEY SPRAGUE, M.D., Representative
from the Rhode Island Medical Society

THE THIRTEENTH Annual Congress on Industrial Health sponsored by the Council on Industrial Health of the American Medical Association was held at the Drake Hotel, Chicago, January 20-22. Undoubtedly many of the fine papers presented at this three-day session will be published over a period of time in the *Journal* of the AMA. Therefore, this report will be in the nature of a personal commentary on some of the features of the Congress as they were noted by your Delegate.

The first day's program was preceded by a Council meeting to which the State Medical Society representatives were invited. Among the new business discussed was the topic of absenteeism in industry, and it was reported that a representative committee has been formed to make a complete study of the problem and report at a later date. The committee on occupational dermatology has been reactivated to include several full-time industrial physicians who will work with the dermatologists to publish information of real value that can be utilized by every physician in his daily practice.

General practitioners were urged, in the report of the committee on professional relations: 1) to visit meetings held in industrial plants and factories; 2) to consider when writing scientific papers whether any phase of industry might affect the condition being reported; 3) to urge under graduate instruction of general practitioners in medical schools; 4) to encourage graduate teaching of general practitioners in the communities of the country; 5) to encourage circulation of "Today's Health" among employees through employer subscriptions.

The Council concluded its business meeting by voting to hold its next session in Louisville, Kentucky, February 22, 23, 24, in 1954.

A YEAR'S ACTIVITIES

Instead of the previous arrangement whereby State representatives gave personal reports on activities of their committees during the previous year, a brief resumé of all the yearly reports was given by Dr. Max R. Burrell, medical director of General Motors Corporation, of Detroit. In spite of the excellence of Doctor Burrell's summary, the consensus of the delegates was that the procedure deprived the State representative from presenting personal information of value to all regarding various problems of industrial medicine encountered in his state. The open discussion that reports have evoked in previous years was missing, and the loss was keenly felt by many of us. It is our hope that another year will witness the return to personal reporting by State delegates.

Dr. Robert O'Connor, division medical director of the Loss Prevention Department of the Liberty Mutual Insurance Company of Boston, reported on the Friday-Saturday seminar in industrial medicine arranged for April, 1953, and sponsored by Harvard University. The seminar, to be given at Harvard by leaders in the field of industrial medicine and surgery will be open to all interested physicians. The fee for the course is $25.

Three speakers reviewed the health problems of the small plant, and how to meet them. In the opinion of your Delegate, Dr. Forrest E. Rieke of Portland, Oregon, gave the best presentation, relating efforts in his area in meeting the small plant problem at 142 industrial concerns.

Community Viewpoints

The program for the second day emphasized the views of community leaders and agencies in how best to maintain the health of the nation's work force. Dr. Rutherford T. Johnstone, Los Angeles psychiatrist, gave a fine talk on the industrial aspects of fear, frustration and futility, pointing out the bearing these psychological factors have on accidents in industry.

Speaking for management William G. Caples, president of the Inland Steel Container Company, presented some fascinating statistical data, while Mr. O. A. Knight, president of the Oil Workers International Union, CIO, hewed the usual organized labor leader's line regarding the necessity for federal supervision, money and guidance in health. Dr. Edward J. McCormick, president-elect of the American Medical Association, answering for medicine in the field of industrial work, gave a brief and forthright talk on the efforts of the AMA to correlate medicine, industry and labor forces for a healthier working population.

Occupational Cancer

The program of the final day was highlighted by an interesting panel on occupational cancer with ex-

continued on next page

cellent papers by Dr. May R. Mayers of New York, chairman of the committee on industrial cancer of the AMA Council on Industrial Health, Dr. Morton Levin, assistant commissioner for medical services of the New York State department of health, and Dr. George T. Pack, attending surgeon, New York Memorial Cancer Center. As part of my report I attach the AMA Council's list of recognized and suspected occupational cancer producing agents, with sites characteristically affected, which I am sure every physician in industrial Rhode Island will find interesting.

Human Relations Factors

A clinic on human relations and occupational health concluded the program. The demonstration was well conceived and worthwhile to every physician. It purported to show how through tact, diplomacy and psychology a person with a difficult personality and some complexes could be oriented to become a useful and progressive member of the work force, as well as a better citizen.

SUMMARY

It was a good meeting, of value to every industrial physician. Most of the lectures were excellent. The motion picture films were better than average and should be used to greater advantage in industrial health education in our plants. However, it appeared to be more of a conference for the representatives of big organizations, and the larger States, than for the medical leaders in industrial health representing the various states who seek from the Congress inspiration and encouragement to initiate workable new programs, and continuance of successful old ones, in their respective local areas.

THREE YEARS OF VOLUNTARY PREPAID SURGICAL INSURANCE IN RHODE ISLAND

concluded from page 137

protection. Our educational efforts should be increased throughout the coming year to the end that every eligible person may possess reliable insurance coverage to meet in part, at least, the costs for surgical and medical care.

SULFONAMIDES AND PENICILLIN IN THE CONTROL OF RHEUMATIC FEVER IN CHILDREN

concluded from page 140

BIBLIOGRAPHY

[1] Harris, T. N.: Studies on the Relation of the H.S. to Rheumatic Fever. Am. J. Dis. Child., No. 4, Oct. 1948.

[2] Rantz, L. A., Spink, W. M., and Boisvert, P. J.: The Etiology and Pathogenesis of Rheumatic Fever. Archives Int. Med., 76:131, 1945.

[3] Swift, H. F.: The Relationship of Streptococcal Infections to Rheumatic Fever. Amer. J. Med. 2:168, 1947.

[4] Windlad, S., Malmiros, H., and Urlander, O.: Studies in Pathogenesis of Rheumatic Fever. Acta Med. Scandin. 133:358, June 14, 1949.

[5] Murphy, G. E., and Swift, H. J.: Induction of Cardiac Lesions closely resembling those of Rheumatic Fever in Rabbit following Repeated Skin Infections with Group A Streptococci. J. Exper. Med. 89:687, June 1949.

[6] Thomas, C. B.: The Prophylactic Treatment of Rheumatic Fever by Sulfanilimide. Bulletin, N. Y. Academy of Med. 18:508, 1942.

[7] Hansen, A. E., Platou, R. V., and Dwan, P. F.: Prolonged Use of a Sulfonamide Compound in Prevention of Rheumatic Recurrences in Children. Am. Jour. Dis. of Child. 6:963, 1942.

[8] Coburn, A. F., and Moore, L. V.: The Prophylactic Use of Sulfonamides in Rheumatic Subjects. Med. Clinics of No. Amer. 24:633, 1940.

[9] Kuttner, A. G.: Prevention of Rheumatic Fever Recurrences. N. Y. State Jour. of Med. 1941-1947, October 15, 1943.

[10] Chandler, C. A. and Taussig, H. B.: Sulfanilimide as a Prophylactic Agent in Rheumatic Fever.

[11] Rublio, S. D., Holmes, M. C., and Stokes, H. L.: Prophylactic Sulfanilimide in Rheumatic Fever: Review of 548 Cases. Lancet, London 2:311-356, August 20, 1949.

[12] Baldwin, J. S.: Sulfadiazine Prophylaxis in Children and Adolescents with Inactive Rheumatic Fever. Jour. of Pediat. 30:284, March 1947.

[13] Lyon, R. A.: The Prevention of Rheumatic Fever. Kentucky Med. Jour. Vol. 7, No. 5, May 1949.

[14] Not published previously.

[15] Maliner, M. M., and Amsterdam, S. D.: Oral Penicillin in the Prophylaxis of Rheumatic Fever. J. Ped. 31:658-661, 1947.

[16] Goerner, J. R., Massell, B. F., Jones, T. Duckett: Use of Penicillin in the Treatment of Carriers of Beta-Hemolytic Streptococci among Patients with Rheumatic Fever. N. E. Jour. of Med. Vol. 237, No. 16, October 1947.

[17] Massell, B. F., Dow, J. W., and Jones, T. Duckett: Orally Administered Penicillin in Patients with Rheumatic Fever. Jour. A.M.A. Vol. 138, No. 14, December 4, 1948.

American Medical Association

Council on Industrial Health

Recognized and Suspected Occupational Cancer Producing Agents, with Sites Characteristically Affected

SUBSTANCES OR CONDITIONS	ORGAN OR SYSTEM	CLASS D*	CLASS E†
Aniline and derivatives	Bladder, ureter, kidney	D	
Anthracene, crude	Skin		E
Aromatic organic chemicals	Liver	D	
Arsenic	Skin		E
	Liver	D	
	Respiratory system	D	
	Eyelids		E
Asbestos	Respiratory system	D	
Asphalt, artificial	Skin		E
	Eye		E
Benzidine and derivatives	Bladder, ureter, kidney	D	
Benzol	Blood forming organs		E
Benzol derivatives	Blood forming organs	D	
Burns, thermic	Skin		E
Chlorinated hydrocarbons	Liver	D	
Chromates	Respiratory system		E
Coal	Skin	D	
Creosote	Skin		E
	Lip		E
	Eye		E
Estrogens	Breast (male)	D	
Frostbite	Skin	D	
Iron dust	Lung	D	
Irritation, chronic	Skin	D	
Mineral oil, crude	Skin and lip		E
	Lip	D	
	Respiratory system	D	
	Eye		E
Naphthylamine—alpha	Bladder, ureter, kidney	D	
Naphthylamine—beta	Bladder, ureter, kidney		E
Nickel carbonyl	Respiratory tract	D	
Paraffin, crude	Skin		E
Pitch	Skin		E
	Lip	D	
	Bladder	D	
	Eye		E
Radiant heat	Skin	D	
Radio active substances	Skin		E
	Lungs		E
	Blood forming organs		E
	Bone		E
Roentgen rays	Skin		E
	Blood forming organs		E
	Subepithelial connective tissues		E
	Eye		E
Shale oil	Skin		E
Sodium nitrate, crude	Skin	D	
Soot	Skin		E
	Bladder	D	
Spindle oils, aromatic	Skin		E
Tar	Lip		E
	Skin		E
	Respiratory system	D	
	Bladder	D	
	Blood forming organs	D	
	Eye		E
Trauma, chemical	Skin	D	
Trauma, physical	Skin	D	
	Blood forming organs	D	
	Mesenchymatous tissues	D	
	Eye	D	
Ultraviolet rays	Skin		E
	Eye		E

Note: *D—Reported cases—etiology still doubtful. †E—Established etiology.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society
106 Francis Street, Providence, Rhode Island

HOSPITAL TRUSTEES

THE CORPORATION of Westerly Hospital has again appointed a physician to membership on its Board of Trustees. This policy begun four years ago initiated a practice in hospital staff and administrative function that is without local precedent.

The recent decision of one of Boston's larger teaching hospitals, Massachusetts Memorial Hospital, to include upon its Board of Trustees three doctors who are chiefs respectively of medicine, surgery and gynecology and obstetrics, appears to set a trend. Hospital trustees and administrators have long failed to recognize the value of, and necessity for, inclusion of the clinician. The hospital is no longer a charitable refuge for the needy sick. Inseparability of physician-trustee interest in patient demands, modified as they are by hospital and medical prepaid care plans, is a development of far reaching influence. It threatens the future care of our sick with something short of success unless this change from the tradition of lay-trusteeism is more widely embraced.

Dependent mutuality of staff, trustee and administrator is obvious. Adoption of this principle of participation by all hospitals cannot be indefinitely deferred in the best public interest. A modern hospital organization must be an efficient business unit. The service it renders has an overall dependence upon the well-trained clinician. Its reputation is reflected in the excellence of his education, skill, experience and judgment. Compromise with this fact is untenable and could be the instrumentation of hospital success or failure.

Well may it be viewed with alarm that the charity concept of hospitals is being submerged. Voluntary insurance plans, to be sure, have contributed to this, but the efforts to promote and develop the hospital as an institution of profit in this era of extremely high hospital costs, is a matter of serious concern. Such a trend could readily cause hospitals to forfeit their tax-exempt status as well as encourage renewed efforts for governmental control of, or participation in, the provision of medical care to everyone.

We are glad to see the physician assuming a directive position in future hospital management, for he is by virtue of educational background as well as professional training, eminently qualified to share such responsibilities and discharge such obligations. Formerly, the physician's most serious problem was his relationship with the patient. This relationship today has extended into a highly involved and complex sphere, that embraces many new phases of current social evolution.

The A.M.A. has consistently maintained a constructive and adjustable perspective toward this problem of Physician-Hospital relationship, emphasizing particularly, "That questions dependent on local conditions must be considered in the first instance at this local level because of the various differences which of necessity exist in many sections of the country."

Creation of committees on Hospital and Professional Relations have implemented this objective as a means of solution rather than a solution itself. Physician members of hospital Trustee Boards will be a decisive step toward a common goal when its value is more widely recognized, and the practice more universally adopted.

"The challenge to those of us in Hospital Administration," said Dr. Madison B. Brown, Executive Vice-President of Roosevelt Hospital in New York City, "is the successful welding of the highly trained often egotistical professional groups with other less skilled members of our Hospital Staff. Your responsibility and mine is to support the doctors with the best of our combined skills, to improve patient care in the hope of a continued advance in the science and art of medicine."

This sound elevation very aptly stated presents an approach, it is to be hoped, will be emulated elsewhere in Rhode Island.

SUBJECTIVE SYMPTOMS

The article in this number of our JOURNAL titled "Medico-Legal Aspects of Hand Dermatoses" is timely in view of the recent extensive discussion in the local press of the medical aspects of workmen's compensation.

It cannot be denied that there have been abuses in the payment for accident cases, the injured persons ceasing work and receiving benefits long after they are reasonably well. In the lay press the responsibility for this situation has been largely placed upon the shoulders of physicians. It should be realized that the honest doctor is placed in a difficult position in many of these cases. It is not the out and out malingerer that makes most of the trouble for us. Honest people are often swayed almost unconsciously by personal interests. Many of us are doing our work with lame backs or other disabilities. Our personal drive, our indifference to pain, many factors determine whether we shall keep at work or give in.

It is reasonably easy when we can form our decisions on objective signs. Subjective symptoms make another story. We see an analogy to the legal maxim "Better a thousand guilty should escape than one honest man wrongly suffer." If we have a reasonable doubt in our mind we feel that we must give the injured person the benefit of that doubt.

It is asking too much always to have the onus for such a judgment rest on one person. Many of these judgments should be made by a review board, and as these judgments always are made largely from a medical viewpoint, it would seem ridiculous not to have medicine represented on such a review board.

The board would realize that there must of necessity be "uncertainties of medical conclusions." They would weigh the "conflicting opinions" and the "preponderance of evidence." If after such fair reviews they often ruled in favor of the person working with known occupational hazards, who can say that they would not on the whole make for justice?

WHAT OTHER ORGANIZATION?

In this issue is published the address of Doctor Joseph C. O'Connell, president of the Rhode Island Medical Society Physicians Service, on the occasion of the third annual meeting of the Corporation of our voluntary prepaid surgical-medical plan. Unfortunately this address will not reach the great majority of people of our State, and the newspapers preferred to stress the total of 314,560 subscribers with little reference to the fact that Physicians Service is one of the most liberal and adequate voluntary programs of its kind in the country.

From the start of Physicians Service every effort was made to render a real service to the subscribers. The schedule of indemnities was scaled below prevailing equitable charges in order to establish a low premium to give as many persons as possible the opportunity to purchase the coverage. Pre-existing conditions were waived where 90% of the employees in plants employing twenty-five or more enrolled.

Persons within specified income limits were guaranteed no extra charge for the surgical procedure. Every beneficiary is sent a copy of the statement of account and invited to communicate with the President of the Service regarding any problem about the payment or the service rendered. Representatives of the public were made members of the board of directors to guarantee a voice in the policy making by the consumer interests.

After a year's experience Physicians Service opened its program for individual membership, *with no age limit*, for the self-employed or the unemployed. In two years more than seventy-one thousand persons have enrolled individually.

The medical profession has never sought acclaim for its countless hours of free service in hospitals, clinics or physicians offices. Nor has it made any effort to glorify the great public contribution of every participating physician who agreed to accept reduced fees at a time when all living costs and wages were rising, in order to support of the voluntory prepaid insurance programs.

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But we may well repeat the question posed by Doctor O'Connell in his analysis of three years' progress of Physicians Service: "What other organization, profit or non-profit, professional or otherwise, today renders a service such as we do to the people of our State through Physicians Service?"

ANSWER THE CALL

The community service calendar for March lists Girl Scouts birthday week, vocational opportunity week, visiting nurse anniversary, Jewish youth week, and Red Cross month. All are worth noting, but certainly the work of the Red Cross is paramount.

Not only in March, but in every month of the year thousands of people in need or distress turn to the Red Cross for the help they must have, help that comes spontaneously from the generous efforts and support of fellowmen everywhere. We know of the great service done by Red Cross in its efforts to make life a little pleasanter for the men and women in the armed forces and the hospitalized veteran. What we probably overlook is the constant readiness of this great organization to aid the sufferers of disaster in every one of our States, and in foreign lands.

As physicians we are among the foremost in the task of coping with civilian disasters. We need no lengthy explanation of how vital are the services of such community units as the Red Cross. We certainly should be among the first to Answer The Call this month to contribute to the support of this great international organization.

BROTHERHOOD AWARD

On February 20 Governor Roberts, on behalf of the Jewish War Veterans, United States of America, Department of Rhode Island, at Temple Beth El, presented our fellow member, Dr. Alex M. Burgess, with an award of merit for his work in the field of brotherhood.

A graduate of Brown in the Class of 1906 and Harvard Medical School in the Class of 1910, Dr. Burgess has passed all but a few years of his entire medical career in the service of this community.

He got away to a quick start, as he was a Professor in the Pathology Department at McGill Medical School within about three years after his graduation. Had he stayed at the teaching career he would have undoubtedly made a great name for himself, as our professors get most widespread recognition, and he was a natural born teacher.

However, it is doubtful if he would have been much more valuable in that way. Ours is a large community, and he has loomed large in it, having been a physician-in-chief in three of our hospitals here. Short periods of time off from this community allowed him to serve abroad in the Navy in World War I, the Chairman of the Medical Teaching Mission to Germany in 1948, and for several years now he has been the Area Medical Section Chief at the Veterans Administration for New England and New York.

There can be few physicians not connected with teaching centers who have been more active in the upper realms of medicine in the United States. A local Governor and a Regent of the College of Physicians, and a Fellow of the American Board of Internal Medicine, he is well known to all those leaders who play a large part in shaping American medicine.

We are proud to congratulate Dr. Burgess on another well-deserved honor.

WORKMEN'S COMPENSATION

A statement to the people of Rhode Island issued through press and radio facilities by Dr. Albert H. Jackvony, President of the Rhode Island Medical Society, in answer to an editorial comment in the Providence JOURNAL-BULLETIN in its issues of February 5, 1953.

As President of the Rhode Island Medical Society I cannot allow the editorial comment in the February 5 issue of the Providence JOURNAL-BULLETIN go unanswered.

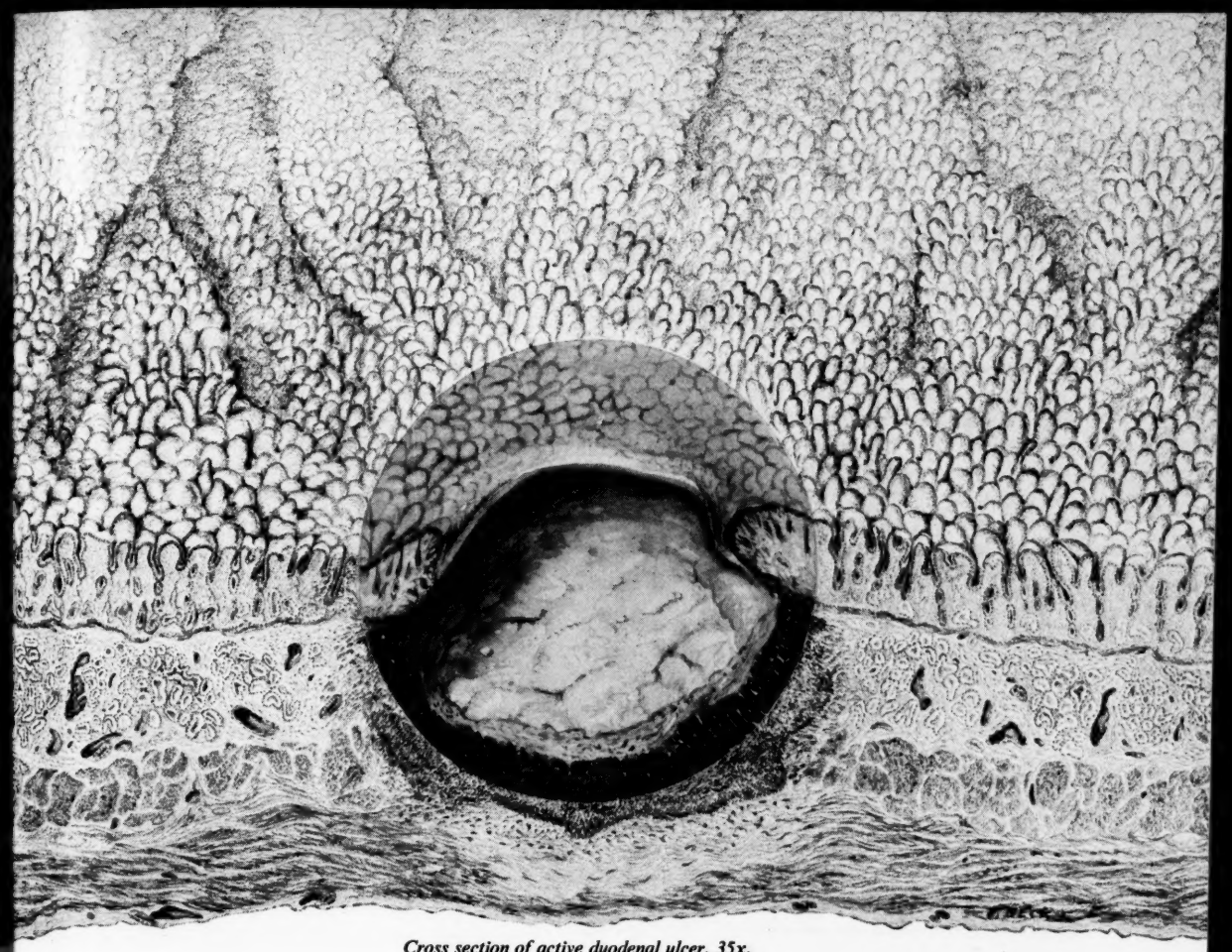
The Rhode Island Medical Society challenged these newspapers to present factual information to substantiate the accusations made in their news columns about certain physicians of this State whom it claims are members of the Society. We stated that we would allow these newspapers to appoint representatives to attend any hearings conducted by the Society regarding any of its members so accused.

Editorially, on February 5, these newspapers offer the answer that they cannot reveal the information from which their articles castigating the medical and legal professions have been built as it was "necessarily given in strict confidence."

Like many other people in this State we strongly suspect that these newspapers cannot substantiate some of their reportings with facts. The articles about the workmen's compensation program are based on supposedly "off the record" conversations with "prominent physicians," suspicions, and questionable conclusions. Who are these witnesses, physicians or otherwise, who dare not stand up and be publicly named? Why do they join with the JOURNAL-BULLETIN behind a cloak of anonymity that protects all of them from legal action if they cannot prove their statements?

The JOURNAL-BULLETIN answers us by saying that the problem of investigation, prosecution and

concluded on page 148



Cross section of active duodenal ulcer. 35x.

Searle Introduces Pro-Banthine*

Smaller dosage, better taste, fewer side effects in new product

The laboratories of G. D. Searle & Co., after continued research in anticholinergic agents, now introduce a new and improved drug for use in the treatment of peptic ulcer, intestinal hypermotility and other parasympathotonic conditions, in its recently perfected Pro-Banthine.

Because of its high potency and greater specificity, Pro-Banthine permits smaller dosage. In a dosage of one tablet (15 mg.) with meals and two tablets at bedtime, minimal side effects may be expected.

Pro-Banthine has a neural inhibiting effect on both the sympathetic and parasympathetic ganglia as well as an atropine-like action on the postganglionic nerve endings of the parasympathetic system.

Provided in oral dosage form—15 mg. sugar-coated tablets.

SEARLE *Research in the Service of Medicine*

*Brand of Propantheline Bromide. Trademark of G. D. Searle & Co.

WORKMEN'S COMPENSATION

concluded from page 146

disciplinary action is entirely one for the Society to handle. At the same time these newspapers make a point of stating that they are not and should not be a prosecuting or disciplinary agency. To this we add that neither is the Rhode Island Medical Society such an agency.

This Society is a voluntary organization in which not all physicians in Rhode Island hold membership. Its purpose is to promote the science and art of medicine and the betterment of public health. Like all professional organizations it stands ready to receive any evidence of unethical practice by any of its members. On the basis of factual evidence, substantiated, the Society may discipline a member by suspending him from membership, or by dropping him from membership.

The Rhode Island Medical Society does not license physicians. It has no power whatever to revoke the license of any physician to practice the healing art. It cannot usurp any of the rights of the civil courts of this State.

If the Society deprives a physician of his membership the action must be supported by truthful information and substantial evidence that will justify the penalty imposed. Loss of membership for unethical practice, with the attendant publicity, might well destroy the future service of a physician to this or any other community. If such actions were taken without sound evidence the physician penalized would be justified in taking legal action against the Society.

The JOURNAL-BULLETIN indicates in its reportings on workmen's compensation cases that frauds have been perpetrated. If such evidence is in the possession of these newspapers then they are derelict in not offering the information they have uncovered to the proper civil authorities for prosecution of the offenders. If insurance companies, self-insurers or others have evidence of the abuses these newspapers claim exist, then they should seek action in the civil courts.

Over a period of time most legislative programs are subject to review and improvement. When the operation of the workmen's compensation program in this State was subject to public discussion in 1946 the Rhode Island Medical Society held meetings with the representatives of the State department of labor, with representatives of insurance companies writing workmen's compensation insurance, and with members of the General Assembly. The Society suggested amendments to the act to improve the medical phases of it. The Society also asked for information regarding any abuses of the program by physicians, and it stated that every case substantiated with evidence would be thoroughly investigated. No evidence was forthcoming, then or since.

Twice we have worked with study commissions appointed by the General Assembly, and we commend these commissions for their willingness to accept our proposals, and for the sincere effort they made to bring about improvements in the entire workmen's compensation law. It is apparent to us, however, that far greater factors are involved in the workmen's compensation program, factors that the JOURNAL-BULLETIN have carefully avoided exploring for reasons best known to themselves.

We have of our own accord introduced in the General Assembly amendments to the medical phases of the law as a constructive step towards improvement of that part of the program. As a voluntary organization concerned with the health and welfare of the people of this State we have always been, and always will be, ready to assume our proper responsibilities.

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of the Fourth Annual Meeting of the Corporation, January 21, 1953

THE FOURTH Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library, Wednesday, January 21, 1953. The meeting was called to order by the President, Dr. Joseph C. O'Connell, at 9:30 p.m.

The following members of the Corporation were in attendance:

Rocco Abbate, M.D.
Charles J. Ashworth, M.D.
Frederic J. Burns, M.D.
Wilfred I. Carney, M.D.
Francis H. Chafee, M.D.
William B. Cohen, M.D.
Edmund B. Curran, M.D.
Frank B. Cutts, M.D.
Morgan Cutts, M.D.
Michael DiMaio, M.D.
Peter C. Erinakes, M.D.
Charles L. Farrell, M.D.
Duncan H. C. Ferguson, M.D.
William J. Fischer, M.D.
Henri E. Gauthier, M.D.
Hannibal Hamlin, M.D.
Albert H. Jackvony, M.D.
Earl F. Kelly, M.D.
Edwin F. Lovering, M.D.
Earl J. Mara, M.D.
Edward A. McLaughlin, M.D.
Mr. James R. Donnelly
Robert G. Murphy, M.D.
Joseph C. O'Connell, M.D.
Thomas Perry, Jr., M.D.
Arnold Porter, M.D.
Alfred L. Potter, M.D.
William A. Reid, M.D.
Louis A. Sage, M.D.
Lee G. Sannella, M.D.
William J. Schwab, M.D.
Linus A. Sheehan, M.D.
Henry E. Turner, M.D.

Also present were Mr. Stanley H. Saunders, Executive Director; Mr. Edgar H. Clapp, Assistant Executive Director; Mr. J. Lewis Eddy, Office Manager; John E. Farrell, Sc.D., Executive Secretary of Physicians Service.

Address of the President

Dr. Joseph C. O'Connell, President of the Corporation, delivered his annual address reviewing the progress and development of Physicians Service. His address is made part of the official minutes of the meeting.

Annual Report of the Secretary

Dr. Morgan Cutts, Secretary, read his annual report, copy of which was distributed to each member of the Corporation present, and which is made part of the official minutes of the meeting.

It was moved that the report of the Secretary be accepted and placed on file. The motion was seconded and adopted.

Annual Report of the Treasurer

Dr. Charles J. Ashworth, Treasurer, reviewed the financial status of Physicians Service as it completed its third year of operation. He submitted a written report to each member present, copy of which is also made part of the official minutes of the meeting.

It was moved that the report of the Treasurer be accepted and placed on file. The motion was seconded and adopted.

Nominations for Board of Directors

The Secretary reported that the House of Delegates of the Rhode Island Medical Society had nominated, to serve for three-year terms as members of the Board of Directors of Physicians Service, the following:

Charles J. Ashworth, M.D., Providence
Albert H. Jackvony, M.D., Providence
Ernest K. Landsteiner, M.D., Providence
Joseph C. O'Connell, M.D., Providence

It was moved that these nominees be elected by the Corporation to serve for three-year terms as members of the Rhode Island Medical Society Physicians Service Board of Directors. The motion was seconded and adopted.

Recognition of Administrative Staff

Dr. O'Connell noted the attendance at the meeting of Messrs. Saunders, Clapp and Eddy of the Administrative Staff, and for the Board of Directors and the Corporation he expressed appreciation for their loyal and efficient efforts in promoting the success of Physicians Service.

Adjournment

The business of the Corporation completed, Dr. O'Connell declared the meeting adjourned at 10:05 p.m.

Respectfully submitted,
MORGAN CUTTS, M.D., *Secretary*

Annual Report of the Secretary January 21, 1953

Since the Corporation meeting last year the Board of Directors has held five meetings to transact important phases of the development of the Physicians Service program.

The Board elected as Officers of the Corporation the following:

Joseph C. O'Connell, M.D., *President*
Rocco Abbate, M.D., *Vice President*

Morgan Cutts, M.D., *Secretary*
Charles J. Ashworth, M.D., *Treasurer*

The Board elected as public representatives on the Board the following:

Walter F. Farrell, President, Providence Union National Bank and Trust Company
George R. Ramsbottom, President, Seekonk Lace Company
John Shepard, II, Shepard Company
James R. Donnelly, Rhode Island Hospital Trust Company

Elected to the Board as additional public representatives were the two following nominees of the Hospital Service Corporation of Rhode Island:

Felix A. Mirando, Secretary-Treasurer, Imperial Knife Company
Emil E. Fachon, President, Bulova Watch Co.

* * *

The Board of Directors organized sub-committees as authorized under the By-Laws, and also established a Claims Committee which it authorized to meet each month to review all problems arising out of the payment of claims. The Board carried out the many problems incidental to the successful administration of the program, including among other matters the investment of reserve funds in government securities, the problem of payment for public ward patients, the direct enrollment campaign, the adoption of requirements relative to duplicate coverage by existing groups now enrolled, the printing of a revised Schedule of Indemnities and list of Participating Physicians, and the complete review, for the purpose of revision, of the Joint Operations Agreement.

A brief statistical summary of the progress of Physicians Service during its third year of operation is as follows:

Subscribers (an increase of 68,871 in the year)	314,516
Amount paid to Participating Physicians	$2,068,922.00
Amount paid to Non-Participating Physicians (anywhere in the world)	469,304.17
Total Assets	1,246,275.87
Investments	697,950.22
Total Reserves	367,081.88
Reserve for Maternity Benefits	302,018.00
Operating Expenses	167,463.24
% of Income for Operating Expenses	5.9%
% Income for Claims	89.2%
Total Cases Processed	65,100

Respectfully submitted,
MORGAN CUTTS, M.D., *Secretary*

January 21, 1953

continued on next page

Annual Report of the Treasurer

Pending the audit now in process of the finances of the Corporation, I submit the following preliminary report at this time:

BALANCE SHEET — DECEMBER 31, 1952

ASSETS

Cash in Banks and On Hand:	Nov. 30, 1952	Dec. 31, 1952	Increase (Decrease)
Operating Account	$ 252,455.23	$ 266,749.81	$14,294.58
Treasurer's Account	5,000.00	5,000.00	.....
Custodian Account	2,942.00	6,848.25	3,906.25
Accounts Receivable (Hospital Serv. Corp.)	233,631.41	269,301.33	35,669.92
Accounts Receivable (Subscriptions)	2,870.52	426.26	(2,444.26)
Investments: U. S. Government Bonds	697,950.22	697,950.22	.....
Prepaid Interest on Bonds	.....	.....	.....
TOTAL ASSETS	$1,194,849.38	$1,246,275.87	$51,426.49

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

LIABILITIES

Accounts Payable (Surgical-Medical Services)	$ 196,486.00	$ 202,644.50	$ 6,158.50
Accounts Payable (Hospital Service Corp.)	12,497.08	16,352.19	3,855.11
Accrued Surgical-Medical Expense	235,256.00	251,061.00	15,805.00
Accrued for Maternity Benefits	297,685.00	302,018.00	4,333.00
Unearned Subscriptions	98,939.75	107,118.30	8,178.55
TOTAL LIABILITIES	$ 840,863.83	$ 879,193.99	$38,330.16
Reserves:			
Statutory Reserve	$ 240,312.15	$ 253,246.08	$12,933.93
Surgical-Medical	113,673.40	113,835.80	162.40
Total Reserves	$ 353,985.55	$ 367,081.88	$13,096.33
TOTAL LIABILITIES AND RESERVES	$1,194,849.38	$1,246,275.87	$51,426.49

As part of this report I also submit a statement of the assets of October 24, 1952 inclusive held for the Corporation in the Trust Department of the Providence Union National Bank and Trust Company of Providence, Rhode Island.

Respectfully submitted,

CHARLES J. ASHWORTH, M.D., *Treasurer*

TRUST DEPARTMENT

THE PROVIDENCE UNION NATIONAL BANK AND TRUST COMPANY
Providence, R. I.

Custodian for Rhode Island Medical Society Physicians Service

STATEMENT:—Assets as of October 24, 1952 inclusive

	SECURITY	B.V.	AMOUNT	MARKET 10/24/52	AMOUNT	INCOME
$ 25,000	U. S. Gov. Treas. Notes Ser. A 1½% 3/15/55 Deposited 1/23/52	98.59376	$ 24,648.44	98.625	$ 24,656.25	$ 375.00
75,000	U. S. Gov. Treas. Notes Ser. B 1¼% 12/15/55 Deposited 1/23/52	99.0625	74,296.88	98.75	74,062.50	1,312.50
200,000	U. S. Gov. Treas. Bonds 2% 6/15/52/54					
	$100,000 deposited 1/23/52	99.94141	99,941.41	99.78125	199,562.50	4,000.00
	$100,000 deposited 9/19/52 Purchased 9/16/52	99.68750	99,687.50			
100,000	U. S. Gov.Treas. Bonds 2½% 6/15/62/67 Deposited 1/23/52	98.72657	98,726.57	98.50	98,500.00	2,500.00

concluded on page 154

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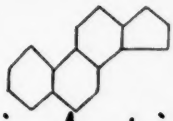
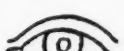
the symbol SCHERING denotes leadership in steroid hormone  research and manufacture -- including Cortogen in the most useful clinical forms. For systemic therapy, use Cortogen tablets SCHERING or injection  . For eye  disorders use Cortogen ophthalmic suspension -- sterile  . The Schering seal SCHERING appears on each tablet and package -- your assurance of quality.

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SCHERING

PHYSICIANS SERVICE—TREASURER'S REPORT, 1952

concluded from page 152

150,000	U. S. Gov. Treas. Bonds 2% 9/15/51/53					
	$100,000 deposited 1/23/52	100.04688	100,046.88	100.03125	150,068.75	3,000.00
	$50,000 deposited 9/18/52 Purchased 9/16/52	100.	50,000.00			
100,000	U. S. Treas. Bonds 2½% 3/15/56/58 Deposited 9/19/52 Purchased 9/16/52	100.50	100,500.00	100.59375	100,593.75	2,500.00
50,000	U. S. Treas. Notes Ser. A dated 10/1/52; due 12/1/53 2⅛% Exchange 1⅞% Ctfs. of Ind. 10/1/52 which were deposited 1/23/52	100.20508	50,102.54	100.15625	50,078.12	1,062.50
$700,000			$697,950.22		$697,521.87	$14,750.00

$200,000	Treas. 2s 52-54 callable 6/15/53
150,000	Treas. 2s 51-53 due 9/15/53
50,000	Treas. 2⅛s Notes due 12/1/53
25,000	Treas. 1½s Notes due 3/15/55
75,000	Treas. 1¾s Notes due 12/15/55
100,000	Treas. 2½s 56-58 callable 3/15/56
100,000	Treas. 2½s 62-67 callable 6/15/62
$700,000	

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The dinner meeting of the Newport County Medical Society was called to order by President Norbert Zielinski on January 28, 1953 at 8:30 p.m. at the Hotel Viking, with 20 members attending.

Minutes of the November meeting were read and approved.

COMMITTEE REPORTS: Dr. Grimes reported on the State Public Relations meeting, at which representatives of the press, hospitals and medical society were present. At the meeting it was pointed out by Mr. Jemail, Newport press representative, that press relations in Newport were excellent. After some discussion, Dr. Dotterer made a motion, seconded by Dr. Malone, that the secretary direct a letter to the editor of the *Daily News*, expressing our appreciation for the cooperation the press has consistently shown to the local physicians.

Dr. Grimes also reported that the optometrists are attempting, by legislation, to eliminate optometrists in department stores and eventually attempt to deprive ophthalmologists from refracting and prescribing glasses.

The following officers were re-elected for the coming year:

President—Norbert U. Zielinski, M.D.
1st Vice President—Robert L. Bestoso, M.D.
2nd Vice President——John M. Malone, M.D.
Secretary—Edward Zamil, M.D.
Treasurer—José M. Ramos, M.D.
Councillor—Samuel Adelson, M.D.
Alternate Councillor—Charles B. Ceppi, M.D.
Delegates—John E. Carey, M.D., Frank J. Logler, M.D.
Censors—Norman M. MacLeod, M.D., Daniel A. Smith, M.D.

The speaker of the evening was Donald B. Fletcher, M.D., Newport Hospital radiologist, who spoke on, "The X-Ray Treatment of Nonmalignant Conditions." He pointed out that in addition to the value of X-Ray in treating malignancy, it is also of benefit in many nonmalignant diseases. He discussed some of the theories of the action of small doses of X-Ray on the tissues. The result of this action is to help the tissues to help themselves. He stated that in many of the acute inflammatory lesions the results of X-Ray treatment are equal to or superior to those of the anti-biotics. There are certain chronic diseases, such as Marie-Strumpell arthritis, in which no other form of therapy can give the benefits to be derived from X-Ray. He elaborated on the following conditions, discussing the relative value of X-Ray therapy in each of them:

A — Acute Inflammatory Lesions
1. Furuncles, carbuncles and cellulitis.
2. Erysipelas.
3. Gas Gangrene.
4. Bursitis.
5. Post-partum mastitis.
6. Post-operative parotitis.

B — Chronic Inflammatory Lesions
1. Tuberculous adenitis of the neck.
2. Chronic hyperplasia of lymph nodes of the pharynx.
3. Marie-Strumpell arthritis.
4. Warts, including plantar warts.
5. Many chronic skin diseases.
6. Hyperkeratoses.

C — Glandular Hyperplasia
1. Pituitary adenoma - basophilic, eosinophilic and chromophobe.
2. Hyperthyroidism.
3. Chronic cystic mastitis.
4. Pre-menopausal excessive menstrual bleeding.
5. Endometriosis.

D — Miscellaneous
1. Types of hemangiomas in infants and children.
2. Enlargement of the thymus with characteristic symptoms.
3. Prevention of keloid formation post-operatively.
4. Peyronie's disease.

He commented briefly on a variety of conditions in which X-Ray has been used with some apparent success, but in which it is not generally agreed that this is the type of treatment of choice.

An interesting question and answer period followed.

Meeting was adjourned at 9:30 p.m.

Respectfully submitted,

EDWARD ZAMIL, M.D., *Secretary*

concluded on page 164

ANNUAL REPORTS — 1952

THE PROVIDENCE MEDICAL ASSOCIATION

ANNUAL REPORT OF THE SECRETARY

The Association has completed a year of outstanding service to the profession and the public. Of particular interest is to be noted the excellent scientific programs held each month from October to May at which physicians from beyond our State have come to Providence to further the educational programs for our members.

The service of our Medical Bureau, now the largest 24-hour telephone service operated exclusively by a medical society anywhere in the East, represents to the public and to our members a service of which we may be proud. Information is furnished persons calling for medical service, and emergency calls from throughout the Greater Providence area are accepted and a physician secured in every instance. Augmenting the public relations committee work, the Medical Bureau now sends out to each person who is given emergency service a letter urging that such person establish contact with a physician who will serve as the "family" physician to be called when needed.

Working behind the scenes our various committees have rendered notable services for the benefit of the membership. Special commendation goes to the committee supervising the Association group health and accident insurance plan, the program committee for our meetings, the advisory committee to the Medical Bureau, and the entertainment committee for the fine golf tournament and annual dinner conducted in June.

During 1952 seven scientific sessions were held with an average attendance well over the hundred mark. In addition, the Association actively supported the annual sessions of the R. I. Medical Society and all its special meetings.

A summary of the meeting programs of the Association is as follows:

January 7 — Presidential Address, Louis I. Kramer, M.D. "Lesions of the Colon, Ileum and Rectum," Frank H. Lahey, M.D., Boston, Massachusetts.

February 4—"Surgical Treatment of Acquired Heart Disease," James H. Walker, M.D., Thoracic Surgeon, New England Deaconess Hospital, and Overholt Thoracic Clinic; "Treatment of Rheumatic Fever in the Light of Recent Developments in Hormonal Therapy," Leo M. Taran, M.D., Medical and Research Director, St. Francis Sanatorium for Cardiac Children, Roslyn, Long Island.

March 3 — "Acute Myocardial Infarction" (Some Observations on 216 Cases), Frank B. Cutts, M.D., Director, Department of Cardiology, Rhode Island Hospital; "Are the Blue Shield Plans Meeting the Need for Health Insurance?" L. Howard Schriver, M.D., of Cincinnati, Ohio, President (since 1946), Blue Shield Medical Care Plans; President, Ohio Medical Indemnity, Inc., Ohio Delegate to A.M.A. House of Delegates; Past President, Cincinnati Academy of Medicine, and Ohio State Medical Association.

April 7—"Highlights of the Providence Air Pollution Control Program," Austin C. Daley, Air Pollution Engineer, City of Providence; "A Pollen Survey of the Providence Area," Francis H. Chafee, M.D., Physician, Department of Medicine, Rhode Island Hospital.

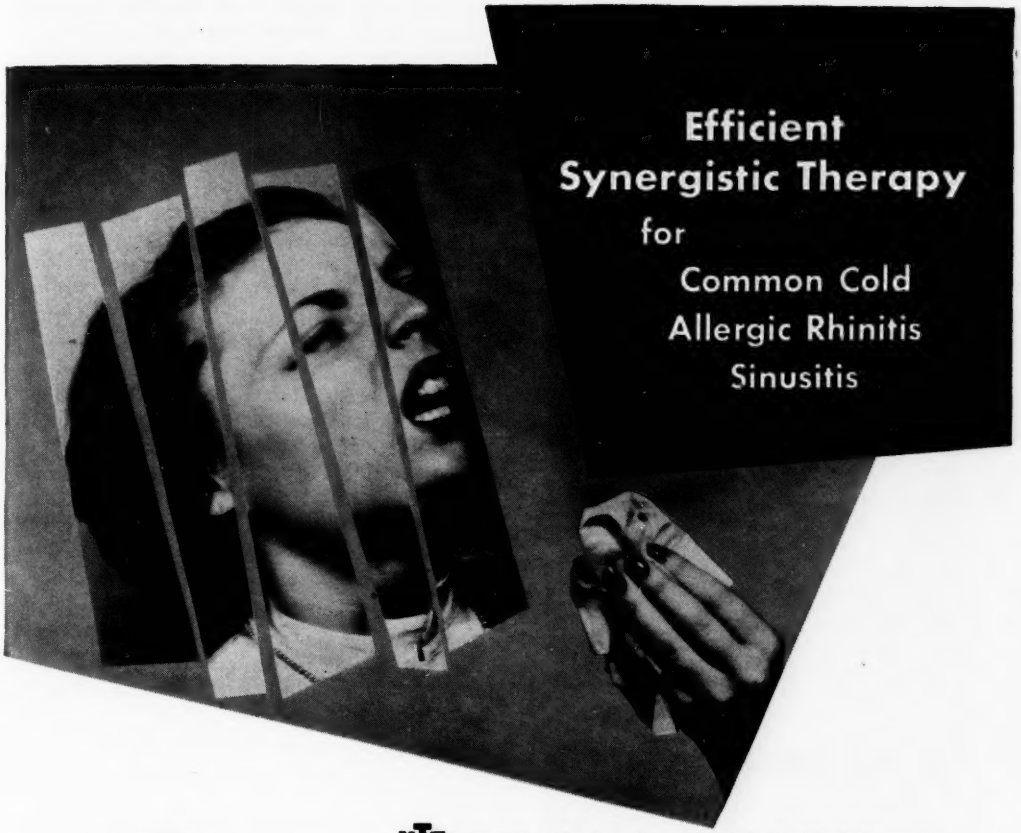
October 6 — "The Experimental and Clinical Correction of Valvular Cardiac Lesions," Charles A. Hufnagel, M.D., Professor of Experimental Surgery, and Director, Section on Cardiac Surgery, Georgetown University Medical Center, Washington, D. C.

November 3—"Ligation of the Uterine Arteries in the Surgical Treatment of Postpartum Hemorrhage," Edward G. Waters, M.D., F.A.C.S., of Jersey City, New Jersey, Division Chief in Obstetrics, Margaret Hague Maternity Hospital, Jersey City; Assistant Clinical Professor in Obstetrics-Gynecology, Columbia University, New York City.

December 1 — "Medical Phases of the State Temporary Disability Compensation Program," William Connell, Chief, Division of Temporary Disability, Department of Employment Security of Rhode Island; "Drafting of Doctors Under the Universal Military Training and Service Act," Lt. Henry S. Kelly, USA, Administrative Officer, and Officer in Charge of Special Registrants, Selective Service in Rhode Island.

The membership of the Association, both active and associate members included, now totals 592. During 1952 eighteen physicians were elected to active membership, two to associate membership, one member was reinstated as an active member,

continued on page 160



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ANNUAL REPORTS

continued from page 158

one resigned from associate membership, one transferred from associate to active membership, and one member was dropped for nonpayment of annual dues.

During 1952 the Association lost thirteen members by death, as follows:

Frank M. Adams, M.D. (August 28, 1952)
John A. Bolster, M.D. (July 4, 1952)
William Fletcher, M.D. (January 17, 1952)
Isaac Gerber, M.D. (February 17, 1952)
Herman P. Grossman, M.D. (June 5, 1952)
Margaret S. Hardman, M.D. (December 16, 1952)
Theodore C. Hascall, M.D., (July 27, 1952)
Frank B. Littlefield, M.D. (June 3, 1952)
Classen Mowry, M.D. (June 17, 1952)
Jesse E. Mowry, M.D. (May 3, 1952)
Jerome J. Ryan, M.D. (July 26, 1952)
Ellen A. Stone, M.D. (February 19, 1952)
Louisa Paine Tingley, M.D. (July 17, 1952)

* * *

Your Secretary takes this opportunity to express his thanks and appreciation to the members of the Association, and particularly those who served on committees, for their excellent cooperation and assistance.

Respectfully submitted,
MICHAEL DIMAIO, M.D., *Secretary*

ANNUAL REPORT OF THE TREASURER

The continuous and rapid rise in all costs of living has resulted in an operating deficit for the Association for the current year.

A study of our financial structure of the past five years shows clearly some of the factors that have created problems affecting our annual operation and annual income. The establishment of the Bristol County Medical Association, the expansion of the Kent County Medical Society which now includes many physicians who formerly belonged to the Providence district, the increase in exemptions from dues to the extent that we now carry 72 members on our roster from whom no assessment is collected—all are factors lessening our annual income.

Over a five-year period the statistics show that our annual income has decreased, and that it offers no likelihood of meeting our basic costs of operation no matter how well we may budget, or even restrict our budget which now covers only the necessary items for efficient and successful administration of your affairs.

Our annual dues have not been increased since 1938. In the same intervening time all operating costs have pyramided until we now find that we have a deficit budget unless our dues are increased,

as has been recommended by the Executive Committee, and as has been done by county medical societies everywhere in the past five years.

I submit the financial report for 1952 showing a deficit of $267.34:

RECEIPTS:

Cash balance, Jan. 7, 1952	$ 210.13	
Dues, current and outstanding	7,560.00	
Dividends	47.50	
Annual dinner receipts	480.00	
Total		$8,297.63

EXPENSES:

Collations after meetings	$ 420.00	
Committees	259.30	
Dinner, annual, and golf tournament	543.40	
Donations to R. I. Medical Society (Use of bldg. and services)	2,352.56	
General expenses (misc.)	636.58	
Journals for library	500.00	
Meetings of Association	541.60	
Office supplies	32.77	
Postage and printing	818.32	
Salary and taxes	2,169.19	
Telephone	291.25	
Total		$8,564.97
Deficit		$ 267.34

Assets in U. S. Government Securities: $2,700.

Respectfully submitted,
ROBERT G. MURPHY, M.D., *Treasurer*

COMMITTEE ON LEGISLATION

Your Committee on Legislation met with the State Committee on the same subject under the Chairmanship of Dr. Fagan. Due to the great care with which our executive Secretary John E. Farrell prepared the various summaries on the proposed State Legislation, the committee was enabled to take definite steps and sides for the various bits of legislation introduced. Needless to say, we have been very successful in our efforts to prevent the enactment of unfavorable legislation while sponsoring various measures which are of benefit to the general population as a whole.

JOSEPH SMITH, M.D., *Chairman*
HENRY S. JOYCE, M.D.
FRANK B. CUTTS, M.D.
FRANK D. FRATANTUONO, M.D.
HILARY J. CONNOR, M.D.

continued on next page

COMMITTEE ON PRE-SCHOOL EXAMINATION

Your committee on pre-school examinations did not have any meeting during the year since, as was reported last year, the Health form which was developed was put into operation. All babies born in Providence received copies of these booklets together with a letter from the Mayor requesting parents to keep these booklets up to date.

We have received much favorable comment from other societies throughout the country. However, these booklets have to be kept up to date through the efforts of the parents and the Physicians. It is hoped that the members of the Medical profession will do their utmost to cooperate in this endeavor.

It is recommended that the Committee on Pre-school examinations be discontinued and that its problems be passed on to the Committee on Medical Care.

JOSEPH SMITH, M.D., *Chairman*
P. JOSEPH PESARE, M.D.
JOHN T. MONAHAN, M.D.
BANICE FEINBERG, M.D.
AMY E. RUSSELL, M.D.

ADVISORY COMMITTEE TO COMMUNITY WORKSHOPS, INCORPORATED

The committee has continued to function in an advisory capacity, has given its opinion in regard to several problems and has attended meetings at which matters vital to the Community Workshops were discussed.

CLIFTON B. LEECH, M.D., *Chairman*
RAYMOND F. HACKING, M.D.
WILLIAM A. HORAN, M.D.
EDWIN B. GAMMELL, M.D.
MAURICE W. LAUFER, M.D.
MERLE M. POTTER, M.D.
VINCENT ZECCHINO, M.D.
FRANCIS D. LAMB, M.D.

DISTRICT MEDICAL SOCIETY MEETINGS

concluded from page 156

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, February 2, 1953. The meeting was called to order by the President, Alfred L. Potter, M.D., at 8:30 p.m.

With the consent of the members, the reading of the minutes of the previous meeting was omitted.

The Secretary reported for the Executive Committee that it recommended for election for Active membership, the following physicians: Peter J. DiGiacomo, M.D., Melvyn Johnson, M.D., Norman L. Loux, M.D.

The Secretary also reported for the Executive Committee that it recommended for election for Associate membership, the following physicians:

Elphege A. Beaudreault, M.D.
Louis C. Cerrito, M.D.
Dominic F. Chimento, M.D.
Charles S. Dotterer, M.D.
Walter J. Dufresne, M.D.
Charles W. Dunbar, M.D.
Patrick A. Durkin, M.D.
Charles L. Farrell, M.D.
William Freeman, M.D.
Francis E. Hanley, M.D.
Henry J. Hanley, M.D.
Joseph C. Kent, M.D.
Frank J. Logler, M.D.
Raymond F. McAteer, M.D.
Victor H. Monti, M.D.
José M. Ramos, M.D.
Daniel A. Smith, M.D.
James F. Sullivan, M.D.
Adrien G. Tetreault, M.D.
Harry Triedman, M.D.
Jeannette E. Vidal, M.D.

It was moved that the physicians nominated for Active and Associate membership be elected. The motion was seconded and adopted.

Dr. Potter introduced as the first speaker of the evening, Dr. Banice Feinberg, Visiting Pediatrician at the Rhode Island Hospital; Physician-in-charge at the Crawford Allen Memorial Hospital; and Clinic Physician of the Rhode Island State Rheumatic Fever Program, who spoke on "Sulfonamides and Penicillin in the Control of Rheumatic Fever in Children."

Dr. Feinberg gave an excellent talk on the rheumatic fever program. His paper will be published in its entirety in one of the forthcoming issues of the RHODE ISLAND MEDICAL JOURNAL.

The second speaker was Dr. Melvin A. Casberg of Washington, D. C., Chairman of the Armed Forces Medical Policy Council, Office of the Secretary of Defense, who spoke on "Medicine at the Department of Defense Level."

Dr. Casberg outlined the provisions of the new draft law as they affect physicians. The proposed changes are an attempt to eliminate inequalities in the present law which expires June 30, 1953.

He pointed out that one of the important provisions of the new law would permit doctors in recognized residency programs to continue their training to completion before being called into the service. Physical standards for physicians have been lowered according to Dr. Casberg. His talk stimulated much active discussion among the several members of the Association.

The meeting adjourned at 10:30 p.m.

Attendance was 98.

Collation was served.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*